



STATE OF NEBRASKA
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
 REGULATION AND LICENSURE - Credentialing Division
 P.O. Box 94986, Lincoln, Nebraska 68509-4986
 402-471-2117

**Medical Nutrition Therapy
 APPLICATION FOR REVIEW OF A
 CERTIFICATE PROGRAM
 CONTINUING EDUCATION PROGRAM**

SECTION A - Name And Address: (Please <u>print</u> your name and full address)		
First:	Middle:	Last:
Street/PO/Route:		
City:	State:	Zip

Date _____ Signature _____

Telephone Number: _____

SECTION B – Certificate Program Information		
1	Name of the certificate program:	
2	Objectives of the program:	

Attach a course outline of the program

NOTE: This application may take 45 days to process from the date of receipt of this application. Please submit your application in a timely manner.

Continuing education must relate to the definition of Medical Nutrition Therapy.

Medical nutrition therapy means the assessment of the nutritional status of patients. It involves the assessment of patient nutritional status followed by treatment, ranging from diet modification to specialized nutrition support, such as determining nutrient needs for enteral and parenteral nutrition, and monitoring to evaluate patient response to such treatment.

After the Board has granted its *written approval* of the application, the provider is entitled to state upon its publications: This program is approved for _____(number) Nebraska Medical Nutrition Therapy continuing education hours.

In accordance with the division's records retention schedule, continuing education application materials will be disposed of after 30 days of the date of the approval letter.

FOR OFFICE USE ONLY - BOARD DETERMINATION	
<input type="checkbox"/> Approved	_____ hours credit
<input type="checkbox"/> Denied, Reason:	_____

(Signature of Reviewer)	(Date)